

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 7 1959

59-042420

210493

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>St. Louis</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Length of stay in 1b		c. CITY OR TOWN <i>SAPPINGTON</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. John's Hospital</i>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>28 SAPPINGTON ACRES</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>ELMER</i> Middle <i>C</i> Last <i>RODENMEYER</i>			4. DATE OF DEATH Month <i>Nov.</i> Day <i>13</i> Year <i>1959</i>				
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>1/28/1892</i>	9. AGE (last birthday) <i>67</i>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>SUPER MARKET</i>		11. BIRTHPLACE (City and state or country) <i>BELLEVILLE, ILL</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>
13a. FATHER'S NAME <i>JOHN RODENMEYER</i>			13b. MOTHER'S MAIDEN NAME <i>ANNA DOMERICK</i>		14. NAME OF HUSBAND OR WIFE <i>DECEASED</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>JEAN PUSATERI 5725 RHODES</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>						INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <i>Hypertensive Cardiovascular Disease</i>				10 yrs	
		DUE TO (c) <i>443x</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <i>7-5-55</i> to <i>11-13-59</i> and last saw him alive on <i>11-12-59</i> Death occurred at <i>12:30 A.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Raymond T. Martin, M.D.</i>			22b. ADDRESS <i>5703 Chypenia St.</i>		22c. DATE SIGNED <i>11-13-59</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		23b. DATE <i>11/16/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>MEMORIAL PARK CEM.</i>		23d. LOCATION (City, town, or county) <i>St. Louis Co., Mo.</i>		(State)
24. FUNERAL DIRECTOR ADDRESS <i>J L ZIEGENHEIN & SONS 7027 GRAYOIS</i>			25. DATE RECD. BY LOCAL REG. <i>NOV 14 1959</i>		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

am

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed B. F. Kedwell

Licensed Embalmer No. 3877

P. O. Address 7027 Graves

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.